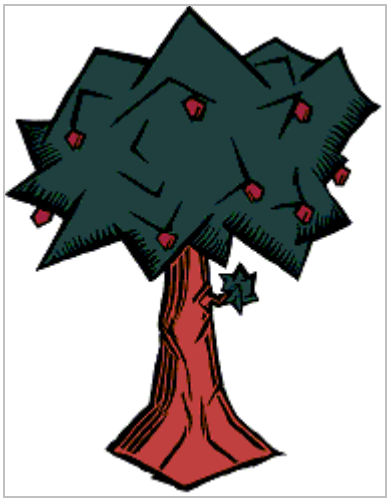
State of Washington

Department of Social and Health Services



MMIS Business and System Requirements Analysis Project

MMIS Needs and Issues Report

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1. Executive Summary

1.1 Introduction

The State of Washington Department of Social and Health Services (DSHS) procured its current Medicaid Management Information System (MMIS) in 1982. The MMIS, as it existed in 1982, and in its present form, meets the federal requirements for "mechanized claims processing and information retrieval systems" for the Medicaid program. The claims processing model defined in the federal requirements embraces a traditional fee-for-service model that was the primary business model used by DSHS at that time. By meeting these requirements, DSHS received, and continues to receive, 75 percent Federal financial participation (FFP) for the operation of its MMIS. In general, the MMIS implemented in 1982 was designed to meet the following objectives, as defined in 42 CFR 433.111:

- Control of title XIX program and administrative costs
- Service to recipients, providers and inquiries
- Operations of claims control and computer capabilities, and
- Management reporting for planning and control

The current MMIS was developed and continues to run in a traditional mainframe-based environment using the development tools that were available in the 1970s and 1980s. These include the use of the online transaction-processing (OLTP) framework provided by IBM's CICS (Customer Information Control System). The MMIS is written in a third-generation programming language, COBOL, using procedural coding techniques that, in many cases, tightly couple the data to the application programs. This means that any modifications made to the MMIS require the intervention of application programmers. Users of the system have very little control over how the system functions to meet business needs.

The MMIS stores its data in non-relational data stores using the proprietary access method, VSAM. The users interact with the system through a character-based user interface developed using CICS that is emulated on Microsoft Windows-based workstations. The user interfaces available for accessing information in the MMIS provide a limited set of querying capabilities.

In short, Washington's MMIS is a legacy system, and legacy systems:

- Are built on obsolete technology
- Are difficult and expensive to modify
- Are difficult to integrate with new applications
- Provide inflexible, less responsive reporting capabilities, and

- Employ less-than-friendly user interfaces

The Washington MMIS, as it was initially implemented, supported the business needs of the Medicaid program – a fee-for-service based business model. Over the ensuing years, the business needs of the program have evolved to meet new legislative mandates – from managed care to SCHIP to HIPAA. The MMIS has failed to keep pace with these evolving business needs. A requirements definition process conducted by DSHS over a six-month period from October 2003 to March 2004 revealed numerous gaps between the current MMIS legacy system and current business needs and best practices. This requirements analysis indicates DSHS needs a modern MMIS to improve the effectiveness of operating and managing Washington State's Medicaid program. In short, the modern MMIS will address the most pressing needs of Washington's Medicaid program, including:

- An MMIS that allows for consolidation of Medicaid and non-Medicaid payment information across the Department. For example, historical medical payments and claim data currently resides on multiple systems and manual processes in various Administrations. This decentralization of data makes it difficult to effectively manage the Medicaid program through comprehensive views of historical data for the entire Medicaid program and its individual clients (e.g., integrated Medicaid Program).
- An MMIS that is easier to maintain and modify without always requiring the intervention of application programmers when the system's behavior must be changed to address a new business need. This will allow DSHS to more easily add and modify programs due to legislative mandates and management decisions.
- An MMIS that provides flexible and responsive reporting options for users and administrators who need information in a timely manner to better serve the Department's constituents – providers, clients, other state government agencies, the state legislature, the governor's office, and CMS.
- An MMIS that provides for improved sharing of information within the Department, for example, an improved interface between the MMIS and the Automated Client Eligibility System (ACES) as well as outside the Department, for example, an improved interface between the MMIS the Agency Financial Reporting System (AFRS), and between the MMIS and Department of Health (e.g., to verify provider credentialing/licensure).
- An MMIS that supports a common provider and client database design to support the sharing of information across DSHS and between agencies and other states.
- An MMIS that automates currently labor-intensive interventions, such as claims adjudication, coordination of benefits, third-party recoveries, and provider enrollment.

- An MMIS that integrates multiple sub-systems (e.g., claims, third-party recoveries, client contracts, etc.) providing improved customer service and support for clients and providers.
- An MMIS that supports receipt of managed care encounter data in standardized formats, providing more data integrity for rate setting activities.

1.2 Project Overview

The Washington MMIS Business and System Requirements Analysis project is the first step in the Medicaid Management Information System (MMIS) re-procurement process. The Department of Social and Health Services (DSHS) and FourThought Group will work together to discover, analyze, and document the state's current and future Medicaid business practices and system needs. At the highest level, the scope of this project is defined by the following project objectives:

- Document the current technological and organizational environment.
- Identify high-level issues with the current MMIS and the high-level needs for the future system.
- Identify the functional and technical system requirements for the future MMIS.
- Analyze alternatives and recommend a future technological infrastructure development strategy.
- Analyze alternatives and recommend a future MMIS procurement strategy.
- Analyze the current state of the Medicaid Medical Eligibility Determination process in DSHS and recommend a future direction for that process.
- Perform a Business Process Review (BPR) for four functional areas of the Medicaid program: MMIS services, Claims Processing and Adjudication, Prior Authorization, and Provider Enrollment.

DSHS has the option of extending the project to include two additional objectives:

- Development of an Advanced Planning Document (APD).
- Development of a Request for Proposal (RFP) for the selected procurement option.

These objectives were derived from the project requirements specified in the Request for Proposal (RFP) developed by DSHS and the proposal submitted by FourThought Group in response to the RFP. Some objectives were derived from additional service contracts awarded after the initial contract. Fulfilling the objectives of this project will establish the basis by which the state can make sound Medicaid technology investments in the future.

The MMIS Needs and Issues report meets the objective to "identify high-level issues with the current MMIS and the high-level needs for the future system."

1.3 Scope

The scope of the Needs and Issues report includes user and stakeholder needs at a high, yet thorough, level. This report states the MMIS needs and issues in sufficient detail to ensure there is an understanding of the need or shortcoming.

The report includes issues and needs identified from stakeholder representatives and needs based on FourThought Group's independent analysis.

This report does not include the detailed requirements for meeting these needs. The detailed requirements for meeting these needs are included in the MMIS System Requirements report.

1.4 Approach

The purpose of the MMIS Needs and Issues report is to list "identified needs and issues related to MMIS" as stated in Section 3.3.3 of the RFP.

FourThought Group collected needs and issues related to the MMIS during the course of this project using many different venues. Issues and needs were collected during the Requirements Gathering JAD process, during interviews when collecting information for other project deliverables, and during initial interviews of stakeholders as part of the project start-up activities.

FourThought Group anticipates that the issues and needs detailed in this report can be used in the Advanced Planning Document (APD) to justify the re-procurement of a new MMIS for the Department.

FourThought Group did not attempt to elicit needs and issues as part of any focused activity; rather, the needs and issues reflected in this report have been gathered from a variety of sources and activities and documented as part of the overall work done on the project.

1.5 Document Overview

The remainder of the document contains the identified needs and issues organized into four categories:

- Functional Needs and Issues – these are needs and issues that identify business functionality lacking in the current MMIS

- Technical Needs and Issues – these are needs and issues that relate specifically to the technical limitations of the current MMIS
- Operational Needs and Issues – these are needs and issues that relate to policies and procedures that exist to circumvent the limitations of the current MMIS
- Other Needs and Issues – these are needs and issues that relate to funding, legislative, federal, or organizational factors.

These categories are purposely broad in nature to reflect the varying range of viewpoints that have been expressed and documented in this report.

The needs and issues are documented in bulleted format and are purposely not presented in any particular priority.

2. Functional Needs and Issues

This section addresses the Department's needs and issues with the current MMIS from a functional perspective.

1. An MMIS that allows for integration of Medicaid and non-Medicaid payment information across the Department. For example, historical Medicaid claim data resides on multiple systems in various Administrations. This decentralization of data creates a high degree of difficulty in providing comprehensive views of historical data for the entire Medicaid program and its individual clients. An example of non-Medicaid payment information is the Kidney Disease Program operated by the Medical Assistance Administration. This program is administered largely through manual processes, is funded solely by the state, and is not currently supported by the existing MMIS; however, the program serves non-Medicaid clients who seek services from current Medicaid providers.

2. An MMIS that supports a common identifier used for all clients, across all systems, within the Department.

3. An MMIS that supports a common identifier used for all providers, across all systems, within the Department.

4. An MMIS that supports robust Surveillance & Utilization Review (SUR) functionality. A robust SUR functionality would more easily allow the Department to detect fraud and abuse of the Medicaid program by both medical providers and clients. It would also provide the Department with the ability to detect and analyze trends and patterns in how providers render services and how clients use services.

5. An MMIS that supports an improved interface with the Agency Financial Reporting System (AFRS) with regard to account codes for financial reporting. The formation of the account code is a complicated process that is driven by limitations of MMIS data. JAD participants envision a new MMIS that would likely store claim, recipient and provider data and have methods to derive account code information from separate fields on the claim record.

6. A more robust drug rebate functionality that allows for an improved process and methodology for resolving disputes with drug manufacturers.

7. An MMIS that allows the Department to serve their clients more efficiently and effectively.

8. An MMIS that provides reliable, correct financial information for forecasting and budgeting. AFRS currently receives financial information from the MMIS. AFRS generates estimates of forecasts of what the Department's budget will look like

in the future. It is very important that the information used in the forecasts is correct as it serves as a way to set budgets. Having a good source of reliable information from the MMIS is important. Today, AFRS collects the data from the MMIS, but the "black box" nature of MMIS and the delay to get specific reporting is inadequate for the future.

9. An MMIS that provides basic accounts receivable information for common Medicaid operations practices such as rebates from drug manufacturers and recoveries from third party insurance carriers. Currently, the MMIS cannot perform the processing needed to generate invoices to drug manufacturers. The MMIS must interface with stand-alone systems located within MAA and at the Financial Services Administration that generate the invoices.

10. An MMIS that supports provider enrollment processes across administrations.

11. An MMIS that supports the ability to identify financial recovery at both the claim and the client level.

12. An MMIS that supports movement toward evidence-based medicine[1], participating and informing studies with State of Washington data.

3. Technical Needs and Issues

This section addresses the Department's needs and issues with the current MMIS from a technical perspective.

1. A more integrated MMIS and Pharmacy POS system. The MMIS and Pharmacy POS are currently two separate systems. Data is stored and displayed separately in the two systems, requiring users to toggle between the two systems for accurate views of a client's claims history. The functionality of these two systems should be seamless.

2. An MMIS that supports an improved interface with the Automated Client Eligibility System (ACES) for eligibility-related information. According to JAD participants, too much time and effort is wasted on resolving differences between the ACES and MMIS systems. MMIS data from ACES should be updated with near real-time regularity.

3. An MMIS that supports the integration of encounter and fee-for-service providers and claims data. Encounter and fee-for-service claims data is currently separated. This makes it very difficult to provide a comprehensive view of client history for any client that has either moved between a managed care and fee-for-service environment over time or who receives fee-for-service and managed care services during the same time period. Additionally, according to JAD participants, managed care network providers are not currently included in the MMIS database.

4. An MMIS that supports the ability to test the impact of policy and procedure changes (for example, billing policy) on the various functional areas of the MMIS (for example, claims processing) before the policy or procedure is enacted.

5. An MMIS that can be changed in a timely manner to meet changing Medicaid program/business needs. Changes to the current MMIS take too long to implement which makes it very difficult to implement new benefit programs or make adjustments to existing benefit programs. In addition, the current MMIS severely hinders the Department's ability to respond to the policy and program changes needed to better serve its clients.

6. To support a modern MMIS, the Medical Assistance Administration needs to design and implement a new technology infrastructure. This need is fully documented in the Technology Analysis Report.

7. An MMIS that allows for the integration of Medicaid services with family and community resources through the practice of exchanging data with both internal and external partners, for example, the Department of Health.

8. An MMIS that supports robust, flexible and responsive reporting capabilities to allow for better decision-making capability. An MMIS that enables more timely turnaround on requests for data and/or reports, including support for user-defined ad hoc reports and on-line inquiries that provide real-time response for routine reporting requests.

9. An MMIS that offers the flexibility to implement state-specific business rules and reduces the dependency on programming staff.

4. Operational Needs and Issues

This section addresses the Department's needs and issues with the current MMIS from an operational perspective.

1. An MMIS that eliminates the need for manual workarounds due to system limitations. JAD participants expressed the need to eliminate operational practices that have been put in place to work around limitations of the current MMIS. For example, MAA uses box 19 of the HCFA/CMS 1500 paper claim form to solicit information from providers that is then used to adjudicate claims. System consolidation across processes may require the need for changes in organizational structure, policies and procedures across Administrations and throughout the Department.

2. The use of the A-19 for one-time claims from providers could potentially be resolved by a new approach to enrolling providers.

3. Dental claims are currently accepted on a variety of claim forms. Policy changes to require dental claims to be submitted on a single form would reduce processing time for dental claims.

4. Confidentiality policies concerning the data collected by the various administrations feeding into the claims systems prevent effective information sharing with MMIS. The system can support necessary data sharing, but to do so, policy changes will need to occur.

5. An MMIS that supports a glossary that can be accessed through help screens or other means of access. JAD participants expressed a need for common definitions of terms such as 'encounters' and 'enrollment' to create a common understanding of the MMIS language used by both Department staff and providers.

6. The aim of the Washington Medicaid Integration Project (WMIP) is to provide integrated services to Medicaid clients across the state. For example, in Snohomish county WMIP is working to provide managed care services in mental health, substance-abuse treatment, and medical care. Currently, these services are provided by different Administrations within DSHS. The opportunity exists to fully integrate the payment for these services through MMIS.

7. An MMIS that supports the need to address formalized training and education modules and ways to facilitate training with features such as on-line tutorials.

8. An MMIS that supports the integration of multiple medical and non-medical benefits programs that are currently delivered by different administrations and systems across the Department.

9. An MMIS that provides flexibility in defining and designing benefits programs for clients. For example, a dental benefit program may provide for the payment of crowns, but only for root canals.

10. An MMIS that supports reducing the redundancy in MAA staff responsible for maintaining provider enrollment information.

5. Other Needs and Issues

This section will address any issues rising from funding, legislative, federal or organizational factors.

1. Ability to see all expenditures of Medicaid dollars in one place.

2. Ability to respond more timely and at less cost to a rapidly changing healthcare industry.

3. The current MMIS has limited capability for support of digital government and e-business initiatives. A modern MMIS with an open architecture will provide more capability for supporting initiatives similar to the Access Washington Internet portal that provides Washington residents with a tool to find the right government agency to answer their questions.

4. An opportunity to competitively procure a new MMIS that has not been competitively procured since 1989.

6. Appendix – Glossary

Numbers

837: The HIPAA compliant Health Care Claims Transaction used by MAA for electronic claim submission.

1099: A federally mandated tax form sent annually to the IRS and to most providers that receive payments from DSHS. There are no deductions from payments to 1099 providers.

A

A-19: A claim form submitted to DSHS by providers of social services.

Access: To retrieve information for purposes of inquiry or update. See also **Electronic Access**.

Access to Baby and Child Dentistry (ABCD): A program that focuses on preventive and restorative dental care for Medicaid-eligible children from birth to age six, with parents encouraged to enroll children by age one.

Accounts Payable (AP or A/P): A record of the state's legal obligation to pay a vendor or provider.

Accounts Receivable (AR or A/R): A record of payments due to the state from providers, vendors, or clients.

Ad Hoc Report: A report generated on an as-needed basis (e.g., a legislative inquiry).

Adjust: To apply a debit or credit to an account or claim amount or to change.

Adult Family Home (AFH): A family home that contracts with DSHS to provide personal care and room and board for one to six adults unrelated to the person(s) providing the care. AFHs are licensed by ADSA.

Affiliated Computer Services (ACS): A large computer service firm that serves MAA as a claim processor and fiscal manager.

Agency Contracts Database (ACD): A database used to maintain contracts with providers. The MMIS Core Provider Agreements (CPAs) are not included in this database.

Agency Financial Reporting System (AFRS): The state financial system of record that includes general ledger, accounting, accounts payable and payments.

Aging & Disability Services Administration (ADSA): One of the seven administrations of DSHS. ADSA brings together long-term care programs, home care, residential care, boarding homes, adult family homes, and nursing homes that are targeted to elderly people and adults with disabilities.

Alert: A brief message or reminder that an online system displays to its users.

Algorithm: A rule or procedure for solving a particular problem.

Alien Emergency Medical (AEM): A program that pays for emergency medical services to non-citizens.

Ambulatory Payment Classification (APC): Categories of services and procedures developed for the facility component of ambulatory care. Included services are ambulatory surgery, emergency room and outpatient procedures, and services performed in ancillary clinic settings.

American Dental Association (ADA): A national organization that establishes standard codes for dental procedures.

American Sign Language (ASL): A complex visual-spatial language used by the deaf community in the United States and English-speaking parts of Canada. It is a linguistically complete, natural language and is the native language of many deaf men and women, as well as some hearing children born into deaf families.

American Society of Anesthesiologists (ASA): An organization of anesthesiologists that establishes anesthesia Procedure Codes that DSHS crosswalks to CPT Procedures.

Ancillary Health Services: Health services ordered but not performed by a physician, including but not limited to, laboratory services, radiology services, and physical therapy.

Applicant: An individual who has applied for assistance from DSHS but is not yet an eligible client.

Application Process: The process by which a DSHS applicant becomes a client, including filing and completion of an application form, in-person interviews, and verification of required information.

Apply: To put into operation or effect.

Assign: To designate or mark for a specific purpose.

Assistance Unit (AU): A group of people who apply for or receive assistance together for a program. A household receiving both TANF and Food Stamps will have two AUs, one for each program.

Associate: To bring together or to connect.

Audit: In claim processing, an automatic validation procedure that compares data on a claim with historical claim data, for example duplicate checking. Historical claim data can also be defined as information on another line on the same claim. Contrast with **Edit**.

Audit Trail: Supplementary information that enables a reviewer to identify each step of a process and its results.

Authorization: For medical services administered by MAA, the process by which a client or provider requests services that are not automatically included in medical benefits. For social services administered by other DSHS Administrations, the process by which a case manager or social worker approves services for a client.

Automated Client Eligibility System (ACES): A data processing system designed to support client, financial, and management activities within DSHS. Through this system, staff enters, update and inquire on data relating to assistance units, clients, other agencies, and providers. ACES maintains eligibility information for most DSHS programs and interfaces with MMIS.

Automatic/Automatically: Done by a computer without human intervention.

Automatic Maximum Allowable Cost (AMAC): An amount on First Databank's Drug File that can be used in pharmacy claim pricing.

Automatic Voice Response System (AVRS or AVR): A telecommunications system that automatically responds to and records calls from interested parties.

B

BarCode: The computer system used by CSOs and others to track applications for benefits and perform application processing.

Batch Processing: A mode of computer processing in which data in submitted to a system and processed at a later time. Contrast with **On-line Processing**.

Beta Test: A second test of a computer system conducted by an entity other than the system developer.

Billing Provider: A provider of medical or medically related services or equipment that submits claims for the services or equipment. A billing provider can be the same as the

performing or rendering provider or it can be a medical group or billing agent with a different name and identifier.

Buy-In: A premium paid by DSHS to the Social Security Administration on behalf of recipients eligible for Medicare.

C

Callback: A feature of voice response systems in which the system automatically returns standard, pre-recorded messages to callers.

Call Management System (CMS): A telecommunications management system used to track incoming calls and to monitor the number of calls, length of calls, and hold times.

Capitation: Payments to health plans based on the number of covered individuals rather than on the services provided. Also called a "Premium." Contrast with **Fee-for-Service**.

Capture: To bring data into a system.

Case and Management Information System (CAMIS): An in-house mainframe system that tracks children's medical, dental, and EPSDT information for the Children's Administration.

Case Manager: A DSHS worker who is continuously responsible for assigned clients.

Case Management System: A computer system that enables case managers and social workers to manage client services and track client use of facilities and resources.

Certified Average Wholesale Price (CAWP): An amount on First Databank's Drug File that can be used in pharmacy claim pricing.

Centers for Medicare & Medicaid Services (CMS): The federal Health and Human Services Agency (formerly called the Health Care Financing Administration or HCFA) that is responsible for Medicare and Medicaid Programs. CMS has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Chemical Dependency (CD): A general term to describe a physical or psychological reliance on drugs.

Children's Administration (CA): One of the seven Administrations' of DSHS. CA is committed to the safe and healthy growth and development of children in their homes, in out-of-home placements, and in day care. CA provides a comprehensive range of services to protect children from abuse and neglect, to support families, and to ensure quality care for children.

Children's Administration Management Information System (CASIS): A case management system that maintain data on CA clients.

Children's Health Insurance Program (CHIP): A program administered by MAA for the State of Washington. CHIP (also called the State Children's Health Insurance Program or SCHIP) is a program operated by the state, in partnership with the federal government under Title XXI of the Social Security Act. The federal government pays 66.28 percent of CHIP expenditures and the state pays 33.72 percent. Children from families with incomes up to 250 per cent of the Federal Poverty Level are eligible for CHIP. Children covered under CHIP receive their medical services from a managed care plan or from MAA's fee-for-service program. Families share in the costs of the program by paying monthly premiums and co-payments for some services.

Claim: A paper or electronic request for payment submitted by a fee-for-service provider.

Claim Form: A pre-printed sheet of paper on which a medical or medically related provider can enter identification and service information and submit for payment. The following claim forms are used by DSHS Administrations: HCFA- (or CMS-) 1500s for physician and practitioner services, UB-92s for inpatient and outpatient institutional services, ADA Forms for dental services. Pharmacy claims are normally submitted with on-line transactions. For non-medical social services, invoices sent by DSHS and returned by providers are equivalent to claims.

Claims Processing Assessment System (CPAS): An annual federal review of claim processing by State Medicaid Agencies.

Claims Processing Functions: Claim edits, audits, and pricing functions normally handled by an automated Claims Processing System.

Clean Claim: A claim that has no defect, impropriety (including a lack of any required substantiating documentation), or particular circumstance requiring special treatment that prevents timely payment.

Client: An eligible person in a program administered by DSHS. Also known as a recipient in the Medicaid environment.

Client Activity and Tracking System (CATS): A system used by the Juvenile Rehabilitation Administration to track juvenile placement, locations, and sentencing.

Client Management Information System (CMIS): An in-house DSHS system that tracks client contact information, including caller information and reasons for contact. CMIS subsystems track enrollments, complaints, recoupments, exemptions, and disenrollments. CMIS makes use of data extracted from MMIS and IPND.

Client on Review: A person receiving benefits who is being scrutinized by DSHS because the Agency has reason to believe that he or she is ineligible for services or is using services inappropriately.

CMS-64: A lengthy, federally mandated report (also known as the HCFA-64) produced by state Medicaid agencies such as MAA. CMS-64 data is the basis for the federal matching funds paid to Medicaid states.

CMS-1500: A standard claim form (also known as the HCFA-1500) for professional services.

Code Set: A group of standard values for a particular data element. Many code sets, including values of HCPCS Procedure Codes, are mandated by HIPAA.

Coinsurance: The portion of a fee-for-service provider's billed charges that Medicare or another non-Medicaid carrier pays for approved medical expenses.

Collection and Accounts Receivable (CARS): A system maintained by the Office of Financial Recovery for use in recovering overpayments.

Community Alternatives Program (CAP): A Medicaid waiver program that provides options in living arrangements to developmentally disabled clients in need of an Intermediate Care Facility - Mentally Retarded (IFC-MR) level of care.

Community Options Program Entry System (COPES): A Medicaid waiver program that provides a client who has been assessed as in need of nursing facility care the option to remain at home or in an alternate living arrangement.

Community Services Office (CSO): A local office of DSHS that provides cash, medical, and food benefits and services to eligible persons within a designated region.

Comprehensive Assessment Reporting and Evaluation (CARE): An in-house system that maintains information on client assessments and service authorizations for administrations other than MAA.

Computer Service Request (CSR): A request by system users for system changes or enhancements submitted on a standard form.

Conman: An in-house DSHS system that maintains contracted expenditures and other contract information.

Contact: An interchange between a DSHS worker and a client, provider, or other party. A contact can be in person, by phone, or by letter or e-mail.

Contact Management System: An automated system that tracks a customer's contacts with DSHS representatives.

Coordination of Benefits (COB): The process by which multiple health insurance carriers determine payments for covered services. Also known as Third Party Liability or TPL.

Co-Payment: The amount that a client pays towards the cost of a medical service. DSHS pays the remainder of the cost up to a set maximum rate.

Core Provider Agreement (CPA) Form: A standard form used to enroll an eligible provider in order to assign a unique provider identifier.

Correcting Coding Initiative (CCI) Edits: A large set of Procedure Code edits that prevent provider unbundling of Codes that are covered by a single comprehensive Code value.

Correspondence: Written communications with outside parties, frequently communications generated by computer systems.

Cost Avoidance: A form of COB in which a payer such as MAA refuses to pay a claim because another carrier is primary and refers the claim to the other carrier. Contrast with **Pay and Chase**.

Create: To make or to produce or bring about by a course of action.

Critical Access Hospital (CAH): A program that was created by the 1997 federal Balanced Budget Act as a safety net device, to ensure that Medicare beneficiaries have access to health care services in rural areas. It allows flexible staffing options relative to community needs, simplifies billing methods and create incentives to develop local integrated health delivery systems, including acute, primary, emergency, and long-term care.

Crosswalk: A list that associates one set of values with another, for example a crosswalk between J Procedure Codes and NDC Drug Codes.

Current Dental Terminology (CDT): A set of dental Procedure Codes created by the American Dental Association. CDT Codes appear within the HCPCS Procedure Code Set.

Current Procedural Terminology (CPT): A set of medical Procedure Codes performed by physicians and other practitioners. CPT Codes are also known as Level 1 HCPCS Codes.

Customer Automated Tracking System (CATS): An in-house system used by the Juvenile Rehabilitation Administration (JRA) that tracks provider and client enrollment and program participation.

D

Data: In a computer system, coded representations of meaningful words, numbers, or pictures. Contrast with **Process**.

Database Management System (DBMS): A sophisticated electronic file structure that optimizes the way in which a system's data is stored and accessed.

Data Warehouse: An integrated collection of computer-based information that is organized to answer strategic, rather than operational, questions.

Decision Support System (DSS): Software and databases designed to help people at all levels of an organization make decisions.

Define: To determine or identify the essential qualities of.

Denial: A determination that a client is not eligible for assistance or that information sufficient to establish eligibility is lacking.

Department of Health (DOH): A State of Washington department outside of DSHS that interfaces with DSHS Administrations in a variety of ways, including immunization registration, provider licensing, and vital statistics.

Department of Social and Health Services (DSHS): A State of Washington Department with seven administrations that provide medical and social services to 1.3 million children and families each year.

Derive: To deduce

Determine: To decide by choice of alternatives or possibilities.

Developmentally Disabled (DD): A category of severely handicapped clients.

Diagnosis Related Group (DRG): A set of codes that MAA uses to price inpatient claims for most Washington hospitals.

Disease Management Organization (DMO): An entity that oversees treatment protocols for patients with serious medical conditions.

Disease Management Program: An MAA program for voluntary case management of clients with serious medical conditions.

Division of Child Support (DCS): A division within ESA that establishes paternity and collects child support for public assistance and non-assistance clients. DCS also determines if a client is not cooperating with support collection activities.

Division of Developmental Disabilities (DDD): A division within ADSA that is responsible for services to developmentally disabled persons.

Division of Employment and Assistance Programs (DEAP): An ESA Division that coordinates services and payments for health screenings for refugees and GA applicants.

Division of Fraud Investigations (DFI): A division within the DSHS Management Services Administration responsible for detection and investigation of fraudulent activities by providers and clients.

Division of Medical Management (DMM): An MAA division that performs medical review and quality assurance.

Documentation: Written and/or graphic material that describes organizational procedures and/or system processes.

Doing Business As (DBA): A name assigned to businesses licensed by the State of Washington, including providers of medical and medically related services.

Drill down: The process of going from high-level information to lower-level information that supports it, for example, drilling down from a claim summary report to detail-level claim data.

Drill up: The process of summarizing lower-level, detailed information into high-level information, for example, drilling up from claims level data to create a claim summary report.

Drug Enforcement Administration (DEA): The federal agency that assigns identification numbers to providers authorized to prescribe controlled drugs.

Drug Manufacturers: Corporations that manufacture prescription and over-the-counter drugs and provide rebates to State Medicaid Agencies for drugs on pharmacy claims.

Drug Rebate: A program in which State Medicaid Agencies apply to drug manufacturers for rebates for portions of payments that they have made for prescription drugs.

Drug Utilization Review (DUR): A feature of point-of-sale (POS) pharmacy claim systems that notifies pharmacists of the potential for adverse drug interactions and other situations in prescribed drugs may be contraindicated.

Durable Medical Equipment (DME): Reusable equipment, such as wheelchairs, required by some patients.

Durable Medical Equipment Region Carrier (DMERC): A Medicare carrier for durable medical equipment.

E

Early and Periodic Screening Diagnosis and Treatment (EPSDT): A federally sponsored program for childhood immunizations, checkups, screenings, and treatments (also called Healthy Kids in Washington State).

Economic Impact Statement (EIS): A report describing the expected financial impact of a proposed activity.

Economic Services Administration (ESA): One of the seven administrations of DSHS. ESA provides economic support, employment training, child support, medical services, and other services to help people in need achieve and maintain self-sufficiency.

Edit: An automatic procedure that checks incoming data for completeness, validity, and consistency. In claim processing, edits are validation procedures that involve a single claim rather than historical claim data. Contrast with **Audit**.

Electronic Access: Access to data maintained by a computer system through a terminal, AVRS, IVRS, Web Site, swipe card, or other device.

Electronic Fund Transfer (EFT): A method of transferring funds by means of electronic transactions rather than paper checks or warrants. EFT payments from Medicaid Agencies to providers and health plans are supported by HIPAA Transactions.

Eligibility: Fulfillment of requirements and meeting of qualifications to receive medical and/or social services. ACES performs eligibility determination functions for most DSHS clients. Contrast with **Enrollment**.

Eligibility Verification System (EVS): An electronic system that tells requesting providers whether or not a person is eligible for benefits.

Eliminate: To remove entirely.

Emergency Room (ER): A section of a hospital for patients with serious injuries or medical conditions in need of immediate treatment.

Employer Identification Number (EIN): A federally assigned identification number similar to a Social Security Number but assigned to businesses and other employers rather than individuals.

Employment Security Department (ESD): A State of Washington Department outside of DSHS that MAA uses to obtain information on provider employees.

Encounter: A paper form or electronic transaction similar in format to a claim but used for reporting rather than to request payment. In the capitated Medicaid environment, health plans submit encounters to Medicaid Agencies such as MAA to report on member services. Contrast with **Claim**.

End State Renal Disease (ESRD): A serious kidney condition that frequently requires dialysis and other very costly treatments.

Enrollee: An individual eligible for medical benefits who participates in a particular program or health plan.

Enrollment: (1) The act of a client's becoming a member of a health plan, either by means of the client's decision or by an automatic process. (2) The act of a medical or medically related provider's applying for participation in the Medicaid Program on either a fee-for-service or capitated basis.

Ensure: To guarantee or make sure of an occurrence

EPIC: A national database of manufacturers' suggested retail prices.

Establish: To institute or bring into existence

Estimated Due Date (EDD): For a pregnant client, a physician's estimate of the date on which the baby will be delivered.

Exception Case Management (ECM): A unit within MAA that works with exceptional client situations such as health plan disenrollment requests and the Patients Requiring Regulation (PRR) program.

Exception to Rule (ETR): A category of authorizations for medical services that are not normally covered by MAA, for example breast reduction surgery for a woman with severe back problems.

Exception to Rule Database: A database used by MAA prior authorization staff to generate worksheets and client notification letters and to track program activity for ETR authorizations.

Executive Administration (EA): The Executive Offices of the DSHS Secretary and Deputy Secretary.

Expedited Prior Authorization (EPA): A method of authorization used by MAA that avoids manual review of authorization requests by analyzing previous authorizations to establish validity criteria for data on incoming claims.

Extended Database (EDB): An MMIS database of paid claims; used in extracting and reporting claims data rather than in claim adjudication.

Extensible Markup Language (XML): An Internet language that support transmission of formatted data.

Extract: To select and separate

F

Federal Employment System: A system that maintains data on federal employees with which MAA interfaces for TPL information.

Federal Medical Assistance Percentage (FMAP): The percentage of state Medicaid expenditures contributed by the federal government. The percentage can differ for different kinds of Medicaid activities.

Federal Poverty Level (FPL): Guidelines developed and updated annually by the federal Department of Health and Human Services (HHS) that are used to establish eligibility criteria for many assistance programs. The FPL specifies income amounts for various household sizes below which people are considered impoverished.

Federal Upper Limit (FUL): Upper limits for drug payment amounts maintained by CMS.

Federally Qualified Health Center (FQHC): A community health center or clinic that provides services to low-income people and meets federal qualifications for receipt of Medicaid payments.

Federal Insurance Contributions Act (FICA): Social Security and Medicare deductions from employee income reported on W-2 Forms. Providers that receive 1099 Forms are responsible for their own FICA contributions.

Federal Unemployment Payroll Surtax (FUDA): Federal contributions to unemployment insurance funds that is deducted from employee income. Providers that receive 1099 Forms are responsible for their own FUDA contributions.

Fee-for-Service (FFS): Payment to providers based on services performed rather than on the number of clients covered. In Washington, the FFS program covers services to elderly and disabled Supplemental Security Income (SSI) clients, clients exempted from Healthy Options or in state administered programs, and Medicaid services not covered by managed care plans. Contrast with **Capitated**.

First Databank: An organization that maintains and distributes up-to-date electronic drug information on a monthly basis. The First Databank Database combines descriptive and pricing data with a selection of advanced clinical support modules.

Fraud Abuse & Detection (FAD): A payment review and audit activity conducted by MAA's Information Services Division.

Frequently Asked Questions (FAQ): A common acronym for answers to questions posted on the Internet.

Full Time Equivalent (FTE): A widely used term for measuring the extent of an employer's employment. A full-time employee, or two half-time employees, is considered one FTE.

G

General Assistance (GA): A state-funded program that provides cash and medical benefits.

General Assistance-Unemployable (GA-U): A state-funded GA program that provides cash and medical benefits for persons who are physically and/or mentally incapacitated and unemployable for more than 90 days. GA-U medical care is limited.

Generic Code Number (GCN): A code assigned to a generic drug category.

Generic Sequence Number (GSN): Same as **Generic Code Number**.

Generate: To create or cause to be created.

GeoAccess: A third party vendor that processes and compiles provider data for the IPND.

Geographic Information System (GIS): A system of computer software, hardware and data used to manipulate, analyze and present information that is tied to a spatial location. Example: DSHS uses location data on providers and clients to analyze the relationship between the two, assess access and provide provider look up services by county, zip code, etc.

Graphic User Interface (GUI): A user interface to a computer system based on graphics (pictures and menus) rather than text. It uses a mouse as well as a keyboard as an input device.

H

Hardcopy: Paper rather than electronic representations of forms and information.

Health Care Authority (HCA): A State of Washington entity that provides health insurance coverage to state employees and sponsors a Basic Health Plan for private sector employees with low incomes.

Health Care Financing Administration (HCFA): The former name for the Center for Medicare & Medicaid Services (CMS), the federal agency legislatively charged with administering the Medicare, Medicaid, and Children's Health Insurance Programs.

Health Care Financing Administration Common Procedure Coding System (HCPCS): The standard code set for Procedure Codes, including CPT Codes and codes for other medical and medically related services. This code set is still called HCPCS in spite of the federal agency's name change.

Health Plan Employer Data and Information Set (HEDIS): A set of federal report specifications created in the early nineties as part of President Clinton's health care initiative and originally intended for use by employers for comparing health plans available for their employees. HEDIS reports can also be used by Medicaid Agencies that contract with capitated health plans to compare service utilization by members of various plans.

Health Plan: An organization that maintains networks of medical providers and pays for medical services for enrolled clients in exchange for a prepaid monthly premium or capitation payment.

Healthy Options (HO): The DSHS Medicaid managed care program for low-income people in the State of Washington. Healthy Options offers eligible families, children under 19 including children in SCHIP, and pregnant women coverage for medical benefits.

Health Insurance Portability and Accountability Act (HIPAA): Federal legislation passed by Congress in 1996 that affects health care activities in a variety of ways. HIPAA Transaction and Code Set and Privacy and Security mandates are of most significance to DSHS.

Health Insurance Premium Payment (HIPP): A state program that pays the employee component of health insurance premiums for low wage workers.

HealthWatch Technologies (HWT): A health care systems company that provides payment accuracy auditing, overpayment recovery, and other services supported by claim data to MAA.

Health Level 7 (HL7): An international set of standard formats for passing health care data among computer systems. HL7 standards differ from the standards mandated by HIPAA Transactions and Code Sets in that they emphasize electronic messages about patients sent between providers rather than communications between providers and health care payers.

Home and Community Based Services (HCBS): A Medicaid waiver program that provides in-home and residential services for people who would otherwise be institutionalized.

Home and Community Based Waiver (HCBW): A directive issued by CMS that enables a State Medicaid Agency to sponsor non-institutional services for clients whose assessments would otherwise require institutional levels of care.

Health Professions Quality Assurance (HPQA): A Washington Department of Health Office that licenses medical providers and investigates complaints from members of the public. HPQA maintains a Provider Licensing File that DSHS accesses to validate provider information at the time of enrollment.

HWT Database: A data warehouse with historical data from MMIS claims and SSPS invoices.

I

Identify: Select as matching a set of criteria.

Immigration and Naturalization Service (INS): The federal agency responsible for immigration procedures.

Infant Toddler Early Intervention Program (ITEIP): An ADSA early intervention program that provides services to children that schools recognize as developmentally disabled.

Information Services Division (ISD): The entity within MAA that administers and maintains computer systems.

Individual Taxpayer Identification Number (ITIN): An identifier assigned by SSA to individual taxpayers who are not eligible to receive a Social Security number.

Input: Data coming into a computer system by means of data entry, electronic transactions, or interface files. Contrast with **Output**.

Integrated Case Management System (ICMS): A system used by the Mental Health Division of DSHS to maintain information on clients.

Integrated Provider Network Database (IPND): A database that maintains information on providers in health plan networks including plans sponsored by MAA and HCA. It is the basis for provider data available from the DSHS Web Site.

Integration: Combining, associating, or bringing together. An integrated system is one in which all components operate consistently and in close association with one another.

Interactive Terminal Input System (ITIS): A client eligibility system formerly maintained by DSHS. ITIS data was converted to ACES in 1996.

Interactive Voice Response System (IVRS or IVR): An automated telecommunications system that provides callers with recorded instructions that enable them to request information and gives responses in English or another language.

Interfaces: Electronic files that are transferred from one computer system to another.

Interim Bill: An inpatient hospital claim that covers a partial rather than a complete stay.

International Classification of Diseases (ICD): The basic code set for medical diagnoses.

Internet: The worldwide network of computer networks that uses teleprocessing protocols to facilitate data transmission and exchange. The Internet is used throughout DSHS as a two-way information source.

InterQUAL: A set of automated decision support tools marketed by the McKesson Corporation.

Invoice Control Number (ICN): A number that identifies a claim including all of the service lines within it.

Involuntary Treatment Act (ITA): State of Washington legislation that permits involuntary commitment if, in the judgment of a county designated mental health professional, a person presents a danger to self, others, or property and/or the person is unable to provide for basic needs of safety and health.

J

J-Codes: HCPCS Procedure Codes for drugs dispensed by a physician rather than a pharmacist. The initial character of these codes is always "J".

Joint Application Development (JAD): A method of eliciting system requirements that features structured group processes and extensive documentation.

Juvenile Rehabilitation Administration (JRA): One of the seven Administrations' of DSHS. JRA provides preventative, rehabilitative, residential, and transitional programs for juvenile offenders.

K

KOVIS: A document scanning and retrieval system used by MAA to store Medicaid provider contracts.

L

Labor and Industries (L&I): The State of Washington Worker's Compensation Agency. It provides cash and medical benefits to eligible persons who are injured while working and interfaces with DSHS for provider employee information.

Length of Stay (LOS): The number of days that a person is in a hospital or residential facility.

Limited Liability Corporation (LLC): A type of business organization registered with the Washington Secretary of State.

Local Procedure Codes: Level 3 HCPCS Procedure Codes established by health care payers and formerly accepted by MAA on claims, especially claims for medical equipment and supplies. Local codes have been replaced by national HCPCS codes on HIPAA compliant claim transactions but are still used internally for claim adjudication within the current MMIS.

Lock-in: A program that restricts selected Medicaid clients to services from particular physicians and/or pharmacists.

Long-Term Care (LTC): A nursing facility in which people who are incapacitated because of age or disabilities reside.

M

Maintain: Keep in an unchanged status.

Manage: To direct or carry on business.

Management and Administrative Reporting Subsystem (MARS): A federally mandated MMIS subsystem that produces financial and utilization reports.

Management Services Administration (MSA): One of the seven Administrations' of DSHS. MSA provides centralized services and support to the public, vendors, Department staff, and facilities.

MAPPER: A client tracking system formerly used by JRA and replaced by CATS.

Maximum Allowable Cost (MAC): An amount on First Databank's Drug File that can be used in pharmacy claim pricing.

Medicaid: The medical assistance program described in Title XIX of the federal Social Security Act. Each state administers a separate Medicaid Program that is financed by both federal matching funds and state funds and is subject to federal review.

Medicaid Eligibility Verification System (MEVS): An interactive electronic system that medical providers use to verify eligibility for Medicaid clients.

Medicaid Management Information System (MMIS): A computer system mandated by CMS for all Medicaid state.

Medicaid Statistical Information System (MSIS): The system that produces the State MSIS Report that provides summary data on Medicaid eligibles, recipients, and services, and on medical provider payments. Since 1972, all states and territories that operate Medicaid programs are required to report annually. The MSIS Report has 14 sections that contain aggregate data broken down by service types and demographic categories.

Medical Assistance Administration (MAA): One of the seven administrations of DSHS. MAA provides health care coverage to low-income families.

Medical Eligibility Determination Services (MEDS): A statewide CSO that determines children's eligibility in an expedited manner for applicants applying for Medicaid.

Medical Personal Care (MPC): A term for chore and personal care services paid by Medicaid.

Medicare: A federally sponsored health insurance program for people over 65 years old.

Medicare Carrier: A private company that contracts with Medicare to pay claims for Medicare beneficiaries.

Medicare Intermediary: A private company that contracts with Medicare to pay Medicare Part A claims for Medicare beneficiaries.

Medicare Enrollment Database (EDB): A national database of Medicare beneficiaries maintained by CMS.

Medicare Physician Fee Schedule Database (MPFSDB): A Medicare Data Base that is used by MAA as a basis for physician's payments.

Membership Billing Maintenance System (MBMS): A system operated by the Health Care Authority and accessed by MEDS for information on changes in eligibility.

Mental Health Division (MHD): A division within the DSHS Health & Rehabilitative Services Administration that is concerned with mental health services.

Modify: To make basic or fundamental changes

N

National Association of Boards of Pharmacy (NAPB): A national organization of state Boards of Pharmacy. State Boards of Pharmacy license pharmacists and support the interests of the pharmacy community.

National Association of Insurance Commissioners (NAIC): An organization of State Insurance Commissions that provides standards and guidelines for the insurance industry.

National Council for Prescription Drug Programs (NCPDP): An organization that maintains standard NDC Drug Codes and a standard, HIPAA compliant format for pharmacy claims.

National Drug Code (NDC): The standard code set for drugs obtained from pharmacies.

National Provider Identifier (NPI): A standard provider identifier to be mandated by HIPAA in conjunction with Provider Taxonomy Codes.

National Uniform Billing Committee (NUBC): An organization that develops and maintains paper and HIPAA compliant electronic standards for institutional claims.

Navigation: In an on-line computer system, the process of going from one computer screen to another.

Nursing Facility (NF): Same as **Long-Term Care Facility**.

Nursing Home (NH): Same as **Long-Term Care Facility**.

O

Office of Financial Recovery (OFR): The DSHS entity responsible for collection of debts owed to the Department, including financial, medical, and food stamp overpayments and Department liens.

Office of the Attorney General (OAG): The state entity responsible for criminal prosecution, including prosecution of fraudulent providers and clients.

OmniTrack: A computer system used by some MAA sections to track client contacts and by other sections to track provider contacts. It is a Sybase system operated by ACS.

On-line Processing: A mode of computer processing in which responses are immediate and interactive. Contrast with **Batch Processing**.

Optical Character Reader (OCR): An electronic device that reads handwritten characters created in a standard format and converts them to electronic data.

Outpatient Prospective Payment System (OPPS): A rule issued by CMS that specifies approximately 400 Ambulatory Payment Classifications (APCs) with relative weights and base payment rates for use in pricing medical and surgical services. APCs serve a role similar to that of DRGs for inpatient services.

Output: Data going from a computer system in the form or a file, electronic transaction, or report. Contrast with **Input**.

P

Patient Participation: The amount of individual financial assets that a client must spend down before the Medicaid program will make payment towards the cost of a medical service. Some states refer to this as a Cost Share.

Patient Requiring Regulation (PRR): A client in a lock-in program who is restricted to authorized providers.

Pay and Chase: A method of COB in which a payer pays claims that may have third party coverage and attempts to recover all or part of the payment amount from another insurance carrier. Contrast with **Cost Avoidance**.

Payment: In claims processing, the system component that generates checks or electronic transactions to transfer money to providers, health plans, and other external entities. Contrast with **Pricing**.

Payment Error Reduction and Measurement (PERM): A program that attempts to identify common claim errors by sampling and reviewing data from Claim History so that error rates can be reduced.

Payment Review Program (PRP): A State of Washington Program that performs post-payment review to identify claim errors that resulted in overpayments to providers and initiates recoveries.

Performing Provider Number: The provider identifier associated with the provider who renders care.

Personal Digital Assistant (PDA): A small, hand-held electronic device used to store information such as phone numbers and schedules.

Personal Identification Code (PIC): An "intelligent" Client Identifier used in the current Washington MMIS. It includes Client Name, Date of Birth, and other data elements that provide unique identification of each individual client.

Pharmacy Benefit Manager (PBM): An entity that processes pharmacy claims. ACS serves as a PBM for DSHS.

Point of Sale (POS) Pharmacy Claim System: A companion system to the MMIS currently operated by ACS in its role as PBM that processes claims for pharmacy benefits.

Portable Document Format (PDF): A widely used format for documents available on the Internet.

Premium: A payment made to an insurance carrier in return for coverage. In an MAA context, "premium" often refers to capitation payments made to health plans.

Price/Pricing: In claims processing, the determination of the amount that a provider should be paid for a particular covered service. Contrast with **Payment**.

Primary Care Provider (PCP): An individual physician, advanced registered nurse practitioner (ARNP), or physician assistant who provides and coordinates medical care services for managed care clients.

Primary Care Case Management (PCCM): An arrangement by which a provider contracts with DSHS as a primary care case management (PCCM) provider to provide health care services to eligible MAA clients under MAA's Managed Care Program.

Primary Care Options Program (PCOP): An MAA program that enables managed care clients to select primary care providers.

Prior Authorization (PA): A process by which clients or providers request MAA approval for certain medical services, equipment, drugs, and supplies, based on medical necessity. MAA approval for the services that require PA is a precondition for provider reimbursement. Expedited Prior Authorizations, Exception to the Rule Authorizations, and Limitation Extensions are forms of prior authorization used by MAA.

Privacy and Security: A HIPAA component that mandates confidentiality of personal medical information and secure maintenance of health care data.

Program of All-Inclusive Care for the Elderly (PACE): A Medicaid waiver program that provides home and community based services to Washington's frail and elderly population.

Procedure, Diagnosis, Drug, and DRG (PDDD) File: A basic Reference File in the current Washington MMIS.

Process: To execute a series of functions designed to achieve a specific result through to completion on a set of data in a computer system. Processes can involve comparison, arithmetic and logical operations, and decisions.

Produce: To make or cause to occur

Protected Population: Clients for whom a special level of confidentiality must be maintained due to their vulnerability or because of the requirements of federal or state legislation. Foster children, adopted children, abused women, JRA clients, and mental health clients are considered protected populations.

Provider: A person, organization, or institution that gives services to DSHS clients

Provider on Review: A provider of services contracted with DSHS who is subject to scrutiny because of suspected fraud, abuse, or inappropriate rendering of services.

Q

Qualified Medicare Beneficiary (QMB): A program under which DSHS pays for Medicare deductibles and co-payments, Medicare Part B premiums, and/or Medicare Part C (which covers HMO premiums and co-payments) for clients who are eligible for both Medicaid and Part A Medicare.

Quality Assessment Improvement and Monitoring (Q-AIM): A section within MAA's Division of Medical Management that measures health care performance, conducts quality control and external quality review studies, monitors health care and service delivery systems, and is responsible for DMM contract development and execution.

Quality Assurance (QA): A process of analysis and review that endeavors to reduce errors and maintain quality for software, data, or procedures.

Query: An electronic request for information from the data maintained by a computer system.

R

Ratio Cost to Charge (RCC): A pricing methodology based on the relationship between the cost of a service and the amount charged for it.

Real Time: Data sharing or processing data functions with immediate and interactive response times.

Reconciliation: The process of comparing separate versions of the same data to ensure that both versions are identical. Client eligibility in MMIS, for example, could be reconciled with eligibility in ACES.

Regional Support Network (RSN): An entity that covers a county or a group of counties that is certified by the Mental Health Division (MHD) of DSHS to administer community mental health programs at a local level. Each RSN contracts with facilities and outpatient providers and distributes block grant funds for authorized mental health services.

Remittance Advice (RA): A paper document or electronic transaction that tells a provider how claims have been adjudicated. RAs are normally issued in association with claim payments.

Request for Proposal (RFP): A document issued by a government agency that solicits proposals for work by external entities. RFPs frequently involve development and/or maintenance of computer systems.

Residential Care Services (RCS): A division of ADSA that sets rules for and inspects residential care facilities.

Resource Based Relative Value Scale (RBRVS): A method of paying physicians for services that places a value on each procedure based on the duration, complexity, skill, and training required to perform the service. MAA multiplies RBRVS values by a statewide factor to determine physician payment rates.

Retain: To keep for a period of time.

Retention Duration: The length of time that a particular kind of data (for example, rate date) is maintained in a computer system.

Return on Investment (ROI): The amount of income or cost savings expected from an expenditure.

Revenue Code: A code set used on institutional claims and encounters to identity particular kinds of service.

Room and Board (R&B): The lodging and food services provided by a residential facility such as a hospice.

Rural Health Center (RHC): A clinic established by the 1977 Rural Health Clinic Act to stabilize access to outpatient primary care in underserved rural areas and encourage the use of physicians, physician assistants, nurse practitioners, and certified nurse midwives (CNMs).

S

S-Codes: Temporary national HCPCS Procedure Codes developed by Blue Cross/Blue Shield and other commercial payers.

Service Limit: A limitation placed by a health care payer on the extent or frequency of a medical service for which it will pay a provider.

Set (Noun): A group of one or more similar entities. (Verb): To apply a pre-determined value or attribute.

Social Security Administration (SSA): The federal agency that administers Social Security and SSI Programs.

Social Security Number (SSN): Identifiers assigned by SSA to employees and employment seekers. SSNs are used primarily to track Social Security contributions and benefits but are also widely used as individual identifiers for other purposes.

Social Service Payment System (SSPS): An automated system used by DSHS administrations outside of MAA to authorize and pay for social services.

Software: The electronic instructions that operate computers and related devices.

Special Low-Income Medicare Beneficiary (SLMB): A Medicaid Program for clients who have applied for or are enrolled in Medicare Part A. Client income limits are over 100 percent but under 120 percent of the Federal Poverty Level. Under SLMB, DSHS pays only the client's Medicare Part B premium.

SSI-eligible clients: Persons who receive federal cash benefits under the SSA's Supplemental Security Income (SSI) Program and who automatically receive Categorically Needy (CN) medical coverage. The federal Social Security Administration (SSA) administers the SSI program. The SSI income standard is the Federal Benefit Rate (FBR).

State Administrated Child Welfare Information System (SACWIS): A case management, payment, and reporting system for foster parents, adoptive parents, and institutions that serve Child Welfare clients.

State Children's Health Insurance Program (SCHIP): Same as the Children's Health Insurance Program (CHIP).

State Maximum Allowable Cost (SMAC): A method of drug pricing that began in 1972 to help control the cost of the pharmacy program. The SMAC process identifies multi-source drugs (e.g., generic drugs) that have actual acquisition costs below established reimbursement rates to providers and adjusts reimbursement rates to make them closer to the actual acquisition costs.

Subset: To create set of elements from a given set.

Superior Court Management Information System (SCOMIS): A case management system used by Washington Superior Courts.

Supplemental Security Income (SSI): A federal program administered by SSA for severely disabled clients. MAA's FFS medical assistance program covers SSI clients.

Support: To perform an action that assists in the performance of another action, as in "support claim processing".

Surveillance and Utilization Review (SUR): A unit within MAA that performs post-payment review to detect fraud, abuse, and inappropriate utilization or provision of services.

Surveillance and Utilization Review Subsystem (SURS): A required MMIS subsystem that performs statistical analysis of claim data to identify providers and clients whose service and utilization patterns deviate from norms.

T

Telecommunications Device for the Deaf (TDD): An electronic device that converts telephone voice messages to written words that deaf people can read.

Temporary Assistance for Needy Families (TANF): A temporary welfare program called Work First in Washington. It was created by Welfare Reform legislation as a replacement for the Aid to Families with Dependent Children (AFDC) Program and gives aid to children and to the adults who care for them.

Therapeutic Consultation Service (TCS): An automated point-of-sale alert that facilitates appropriate and cost-effective use of prescription drugs.

Timing: The time frame in which a data processing activity is accomplished; on-line or batch.

Third Party Liability (TPL): Same as **Coordination of Benefits (COB)**.

Title XIX: The portion of the federal Social Security Act that covers Medicaid.

Title XXI: The portion of the federal Social Security Act that covers the Children's Health Insurance Program (CHIP).

Track: Maintain the identity and status of an entity as it is processed repeatedly by an automated or manual system.

Transaction Control Number (TCN): A unique field value that identifies a claim transaction assigned by Washington's MMIS.

Transactions and Code Sets (TCS): A HIPAA component that mandates formats for electronic transactions related to health care payment and specifies sets of data element values that are valid on transactions.

Transportation and Interpreter Services Section (TISS): An MAA Section that provides transportation and interpreter services to MAA clients. Transportation services are arranged through transportation brokers.

Transportation Brokers: Entities with which MAA contracts to arrange medical transportation services to Medicaid clients. Brokers screen client requests for eligibility and arrange the most appropriate and least costly method of transportation for clients, including public buses, gas vouchers, client and volunteer mileage reimbursements, nonprofit providers, taxies, "cabulances", and commercial buses and airlines.

Treatment and Assessment Report Generation Tool (TARGET): A system maintained by the DSHS Division of Alcohol and Substance Abuse (DASA) that maintains chemical dependency residential treatment data.

U

United States Post Office (USPS): An entity that, in addition to delivering mail, establishes standards for address components.

Universal Billing (UB): The basic claim form used for institutional services.

Universal Provider Identification Number (UPIN): The number used by Medicare to identify providers.

Update: To add, change, or delete the value of a field or set of fields.

V

Value: (Verb) To establishing a claim's payment amounts by using all appropriate methods of pricing.

W

W-2: The tax form that DSHS sends to individual employees and to the IRS. It shows FICA, FUDA, and other deductions from employee payments.

Washington Administrative Code (WAC): A set of rules governing the administration of federal and state laws and court decisions. Many DSHS policies and decisions reference particular WACs.

Washington Medical Integration Project (WMIP): A DSHS program developed to examine the potential benefits of providing services in a more integrated fashion to aged and disabled clients who receive medical care, mental health treatment, and long-term care services.

Working Connections Automated Program (WCAP): A client registry and case management system used by the WCCC Program.

Women, Infants & Children Program (WIC): A supplemental nutrition program for women, infants and children.

Worker's Compensation: Insurance that employers are required to have to cover employees who become sick or injured on the job.

Working Connections Child Care (WCCC): A DSHS program that helps families with children pay for child care to find jobs, keep their jobs, and get better jobs.

7. Appendix – References

[1]From http://www.hsl.unc.edu/lm/ebm/whatis.htm:

> The most common definition of Evidence Based Medicine (EBM) is taken from David Sackett. EBM is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research."
>
> EBM is the integration of clinical expertise, patient values, and the best evidence into the decision making process for patient care. Clinical expertise refers to the clinician's cumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal and unique concerns, expectations, and values. The best evidence is usually found in clinically relevant research that has been conducted using sound methodology. (Sackett, D.)